PEDIATRIC NURSING PROGRESS REPORT

Temperature/Route

Respiration

PULSES
Radial

Apical

HEIGHT _____
☐ Actual
☐ Stated
☐ Unable
☐ Client tape
☐ Agency tape
☐ Changes_____

WEIGHT _____
☐ Actual
☐ Stated
☐ Unable
☐ Client scale
☐ Agency scale
☐ Changes_____

BLOOD PRESSURE

Standing	Sitting	Lying
☐ Left	☐ Left	☐ Left
☐ Right	☐ Right	☐ Right
☐ NA		

SYSTEMS ASSESSMENT - Check appropriate items & fill in blanks.

CARDIOVASCULAR
☐ Pulse regular
☐ Pulse irregular
☐ Abnormal heart sounds
_____
☐ Chest pain
_____
☐ Edema/fluid retention
_____
☐ Neck vein distention
☐ Pedal pulses
L _____ R _____
☐ Numbness
☐ Tingling
☐ Murmur
☐ Other
_____
☐ WNL for client

RESPIRATORY
☐ Lungs Clear
☐ Rales
☐ Wheeze
☐ Labored
☐ Cough/Sputum
_____
_____
☐ SOB / DOE
☐ O2_____
☐ Tracheostomy
☐ Ventilator
Mode_____
T.V._____
Rate_____
IE Ratio_____
↑Pressure Limit_____
↓Pressure Limit_____
☐ Other Findings:
_____
☐ WNL for client

MUSCULOSKELETAL & MOBILITY
☐ Endurance_____ft.
☐ Active ROM, all extremities
☐ Bed bound
☐ Gait steady
☐ Gait unsteady
☐ Partial weight bearing
☐ Non-weight bearing
☐ Non - ambulatory
☐ Cerebral Palsy
☐ Pain, weakness, injury
_____
☐ Prosthesis
_____
☐ DME
_____
☐ Other
_____
☐ WNL for client

MENTAL & EMOTIONAL
☐ Oriented ☐ Labile
☐ Cooperative ☐ Agitated
☐ Disoriented ☐ Fearful
☐ Forgetful ☐ Anxious
☐ Withdrawn
☐ Depressed
☐ Lethargic
☐ Special needs
☐ Social isolation
☐ Appropriate for age
☐ Developmental Delayed
Developmental age _____
☐ Other
_____
☐ WNL for client

NEUROLOGICAL
☐ Awake
☐ Alert
☐ Drowsy
☐ Headache
☐ Dizziness
☐ Visual deficit
_____
☐ Hearing deficit
_____
☐ Speech difficulty
☐ Swallowing difficulty
☐ Pupils unequal
☐ Pupil response
L _____ R _____
☐ Hand grasp
L _____ R _____
☐ Other
_____
☐ WNL for client

HOMEBOUND STATUS
☐ Immunosuppressed
☐ O2 dependent
☐ Acute illness
☐ Impaired mobility
☐ Severe dyspnea
☐ Severe pain
☐ Incontinence
☐ Wound
☐ Poor cardiac reserve
☐ Other
_____
☐ Technology dependent child
_____

NUTRITIONAL & HYDRATION
Appetite
☐ Good ☐ Fair
☐ Poor ☐ N/A
DIET
☐ Regular ☐ Special
☐ Pureed
☐ Finger food
☐ Formula
_____oz/day
☐ Bottle ☐ Cup
☐ G.Tube ☐ J.Tube
☐ Bolus
☐ Pump _____
Rate _____
☐ TPN
_____

GASTROINTESTINAL
☐ No identified problems
☐ Bowel sounds x 4
☐ Last BM _____
☐ Diarrhea
☐ Constipation
☐ Nausea
☐ Vomiting
☐ Incontinence
☐ Abdominal girth
_____
☐ Ostomy
_____
☐ Diapers
☐ Toilet trained
☐ Laxative use
☐ WNL for client

GENITOURINARY
☐ No identified problems
☐ Incontinence
☐ Retention
☐ Foley catheter
_____
☐ Urine characteristics
_____
☐ Burning
☐ Pain
☐ Urgency
☐ Frequency
☐ Ostomy
_____
☐ Diapers
☐ Toilet trained
☐ WNL for client

SKIN
☐ Normal ☐ Dry
☐ Warm ☐ Cold
☐ Diaphoretic
☐ Pallor
☐ Cyanosis
☐ Turgor
_____
☐ Wound ☐ Lesions
☐ Rash ☐ Incision
☐ WNL for client

* Document wound appearance on pg 2

DEVELOPMENTAL PROGRESS

COMFORT
☐ Absence of pain
☐ Complaint of pain
Location_____
Severity:
1 2 3 4 5 6 7 8 9 10
MILD SEVERE
☐ Pain control measures
Medication_____
Frequency_____
Response_____
☐ Increased pain with activity
☐ Other
_____
_____
☐ WNL for client

VENOUS ACCESS
☐ Not applicable
☐ Hickman
☐ Mediport
☐ PICC
☐ Groshong
☐ Portacath
Location_____
Appearance_____
☐ Single Lumen
☐ Double Lumen
☐ Triple Lumen

IV SITE CARE
☐ Not applicable
☐ Cap change
Frequency_____
☐ Dressing change
Describe
_____
_____
☐ Flush
Describe
_____
_____
☐ Extension tubing change

LABS/SPECIMENS
☐ Not applicable
☐ CBC/PLT
☐ Chem Panel
☐ Protime / INR
☐ Creatine
☐ BUN
☐ 24 hour urine
☐ Culture
☐ FBS
☐ RBS
☐ UA
☐ Other
_____
_____
_____

INJECTION & IV'S
☐ Not applicable
☐ IM ☐ IV ☐ SQ
Medication_____
Frequency_____
Response_____

IMMUNIZATIONS
☐ Current
Due ☐

Client Name _____

HC # _____

Diagnosis _____

VISIT TYPE
☐ Skilled Nursing
☐ PRN
☐ Hi-Tech

Frequency _____
Visit Date _____
Time In _____
Time Out _____

MD VISITS:
Date of Last _____
Date of Next _____

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NURSE DIAGNOSIS

1. Activity intolerance
2. Bowel elimination, alteration
3. Urinary elimination alteration
4. Altered Cardiac Function
5. Comfort altered
6. Coping: ☐ Client ☐ Caregiver
7. Skin integrity impairment
8. Social isolation
9. Fluid volume alteration
10. Home maintenance impaired
11. Inconsistent therapeutic follow- through by: ☐ Client ☐ Caregiver
12. Infection: ☐ Potential ☐ Actual
13. Injury: ☐ Potential ☐ Actual
14. Mobility impaired
15. Knowledge deficit RT:_____ _____ ☐ Client ☐ Caregiver
16. Metabolic disturbance
17. Nutritional alteration
18. Respiratory function, altered
19. Self care deficit
20. Sensory-perceptual alteration
21. Sleep pattern disturbance
22. Thought process alteration
23. Medication Compliance
24. Other: _____

Intervention/Disease Specific Assessment	Response to Intervention	Outcome

Patient responding to treatment? ☐Yes ☐No
Describe _____

Patient remains at risk for: _____

Discharge Plan: ☐Yes ☐No
Discussed with: ☐Client ☐Family ☐Caregiver ☐MD

Contacted: ☐MD ☐PT ☐OT ☐MSW ☐ST ☐RT ☐HHA ☐Hospice ☐Pharmacy ☐Dietician ☐Clergy ☐Volunteer ☐Other; _____

Orders: ☐New ☐Changed ☐None

Supplies Used _____

Supplies Ordered _____

Plan for Next Visit _____

Next Visit Date: _____

Nurse Signature & Title _____ **Date** _____ ☐ **Billable** ☐ **Non-Billable**

Client Name _____ **HC#** _____ **Visit Verification Signature** _____

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